ENDODONTIC THERAPY
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Specialized in Microscope Guided
Conventional and Surgical Endodontics
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Appointment Made For: _____

Appointment Date: _____

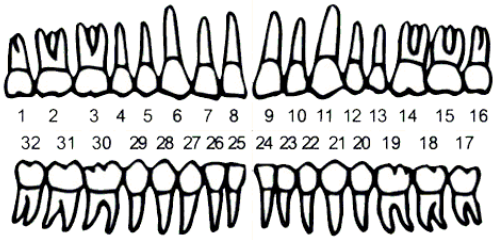
*This time is reserved specifically for you. If by necessity you must cancel your appointment, please notify us at least **24 hours** in advance.*

Referring Doctor: _____

Referring Dr.'s Phone: _____

Today's Date: _____

PLEASE EVALUATE / TREAT THE FOLLOWING TEETH:



- ❑ This Tooth/Teeth Require(s) Root Canal Therapy
  - ❑ Symptomatic ❑ Pre-Pros/Prophy-Endo
- ❑ This Tooth/Teeth Require(s) Retreatment
  - ❑ Existing Post
- ❑ This Tooth Requires Periapical Surgery
- ❑ Evaluate and Treat as Necessary
- ❑ Evaluate Only and Call Me

- ❑ Patient has Pain / Swelling / Sensitivity
- ❑ Tooth Started / Accessed / Instrumented
- ❑ Pre-Medication Required
- ❑ Questionable Prognosis
- ❑ Existing Crown/Bridge
  - ❑ Permanent Cement ❑ Temporary Cements
- ❑ Crown will be Replaced:
  - ❑ Yes ❑ No ❑ Maybe

- ❑ Post Space Required
- ❑ Place the Post / Core
- ❑ Perform Crown-legthening if necessary

Additional Comments: _____